



**University of
Zurich**^{UZH}

**Zurich Open Repository and
Archive**

University of Zurich
University Library
Strickhofstrasse 39
CH-8057 Zurich
www.zora.uzh.ch

Year: 2021

Measuring physical activity with activity monitors in patients with heart failure: from literature to practice. A position paper from the Committee on Exercise Physiology and Training of the Heart Failure Association of the European Society of Cardiology

Klompstra, Leonie ; Kyriakou, Martha ; Lambrinou, Ekaterini ; Piepoli, Massimo F ; Coats, Andrew J S ; Cohen-Solal, Alain ; Cornelis, Justien ; Gellen, Barnabas ; Marques-Sule, Elena ; Niederseer, David ; Orso, Francesco ; Piotrowicz, Ewa ; Van Craenenbroeck, Emeline M ; Simonenko, Maria ; Witte, Klaus K ; Wozniak, Anna ; Volterrani, Maurizio ; Jaarsma, Tiny

Abstract: The aims of this paper were to provide an overview of available activity monitors used in research in patients with heart failure and to identify the key criteria in the selection of the most appropriate activity monitor for collecting, reporting, and analysing physical activity in heart failure research. This study was conducted in three parts. First, the literature was systematically reviewed to identify physical activity concepts and activity monitors used in heart failure research. Second, an additional scoping literature search for validation of these activity monitors was conducted. Third, the most appropriate criteria in the selection of activity monitors were identified. Nine activity monitors were evaluated in terms of size, weight, placement, costs, data storage, water resistance, outcomes and validation, and cut-off points for physical activity intensity levels were discussed. The choice of a monitor should depend on the research aims, study population and design regarding physical activity. If the aim is to motivate patients to be active or set goals, a less rigorously tested tool can be considered. On the other hand, if the aim is to measure physical activity and its changes over time or following treatment adjustment, it is important to choose a valid activity monitor with a storage and battery longevity of at least one week. The device should provide raw data and valid cut-off points should be chosen for analysing physical activity intensity levels. Other considerations in choosing an activity monitor should include data storage location and ownership and the upfront costs of the device.

DOI: <https://doi.org/10.1002/ejhf.2035>

Posted at the Zurich Open Repository and Archive, University of Zurich

ZORA URL: <https://doi.org/10.5167/uzh-200490>

Journal Article

Published Version



The following work is licensed under a Creative Commons: Attribution-NonCommercial 4.0 International (CC BY-NC 4.0) License.

Originally published at:

Klompstra, Leonie; Kyriakou, Martha; Lambrinou, Ekaterini; Piepoli, Massimo F; Coats, Andrew J S; Cohen-Solal, Alain; Cornelis, Justien; Gellen, Barnabas; Marques-Sule, Elena; Niederseer, David; Orso, Francesco; Piotrowicz, Ewa; Van Craenenbroeck, Emeline M; Simonenko, Maria; Witte, Klaus K; Wozniak, Anna; Volterrani, Maurizio; Jaarsma, Tiny (2021). Measuring physical activity with activity monitors in patients with heart failure: from literature to practice. A position paper from the Committee on Exercise Physiology and Training of the Heart Failure Association of the European Society of Cardiology. *European Journal of Heart Failure*, 23(1):83-91.
DOI: <https://doi.org/10.1002/ejhf.2035>

Measuring physical activity with activity monitors in patients with heart failure: from literature to practice. A position paper from the Committee on Exercise Physiology and Training of the Heart Failure Association of the European Society of Cardiology

Leonie Klompstra^{1*}, Martha Kyriakou^{2,3}, Ekaterini Lambrinou², Massimo F. Piepoli⁴, Andrew J.S. Coats⁵, Alain Cohen-Solal⁶, Justien Cornelis^{7,8}, Barnabas Gellen⁹, Elena Marques-Sule¹⁰, David Niederseer¹¹, Francesco Orso¹², Ewa Piotrowicz¹³, Emeline M. Van Craenenbroeck¹⁴, Maria Simonenko¹⁵, Klaus K. Witte¹⁶, Anna Wozniak¹⁷, Maurizio Volterrani¹⁸, and Tiny Jaarsma^{1,19}

¹Department of Health, Medicine and Caring Sciences, Linköping University, Linköping, Sweden; ²Department of Nursing, School of Health Sciences, Cyprus University of Technology, Limassol, Cyprus; ³Intensive Care Unit, Nicosia General Hospital, Nicosia, Cyprus; ⁴Heart Failure Unit, Cardiology, G. da Saliceto Hospital, Piacenza, Italy; ⁵Monash University Australia and University of Warwick, Warwick, UK; ⁶Paris University, Cardiology Department, Lariboisière Hospital, Paris, France; ⁷Faculty of Medicine and Health Sciences, Translational Pathophysiological Research, University of Antwerp, Antwerp, Belgium; ⁸Belgian Health Care Knowledge Centre (KCE), Brussels, Belgium; ⁹ELSAN, Polyclinique de Poitiers, Poitiers, France; ¹⁰Department of Physiotherapy, University of Valencia, Valencia, Spain; ¹¹Department of Cardiology, University Heart Center Zurich, University Hospital Zurich, University of Zurich, Zurich, Switzerland; ¹²Section of Geriatric Medicine and Cardiology, Department of Geriatrics, Careggi University Hospital, Florence, Italy; ¹³Telecardiology Center, National Institute of Cardiology, Warsaw, Poland; ¹⁴Department of Cardiology, Antwerp University Hospital and Research Group Cardiovascular Diseases, University of Antwerp, Antwerp, Belgium; ¹⁵Physiology Research and Blood Circulation Department, Cardiopulmonary Exercise Test SRL, Heart Transplantation Outpatient Department, Federal State Budgetary Institution, 'V.A. Almazov National Medical Research Centre' of the Ministry of Health of the Russian Federation, Saint Petersburg, Russian Federation; ¹⁶Leeds Institute of Cardiovascular and Metabolic Medicine, University of Leeds, Leeds, UK; ¹⁷Cardio-Respiratory Department, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Doncaster, UK; ¹⁸Department of Cardiovascular and Respiratory Sciences, IRCCS San Raffaele Pisana, Rome, Italy; and ¹⁹Julius Center, University Medical Center Utrecht, Utrecht, The Netherlands

Received 11 August 2020; revised 16 October 2020; accepted 26 October 2020

The aims of this paper were to provide an overview of available activity monitors used in research in patients with heart failure and to identify the key criteria in the selection of the most appropriate activity monitor for collecting, reporting, and analysing physical activity in heart failure research. This study was conducted in three parts. First, the literature was systematically reviewed to identify physical activity concepts and activity monitors used in heart failure research. Second, an additional scoping literature search for validation of these activity monitors was conducted. Third, the most appropriate criteria in the selection of activity monitors were identified. Nine activity monitors were evaluated in terms of size, weight, placement, costs, data storage, water resistance, outcomes and validation, and cut-off points for physical activity intensity levels were discussed. The choice of a monitor should depend on the research aims, study population and design regarding physical activity. If the aim is to motivate patients to be active or set goals, a less rigorously tested tool can be considered. On the other hand, if the aim is to measure physical activity and its changes over time or following treatment adjustment, it is important to choose a valid activity monitor with a storage and battery longevity of at least one week. The device should provide raw data and valid cut-off points should be chosen for analysing physical activity intensity levels. Other considerations in choosing an activity monitor should include data storage location and ownership and the upfront costs of the device.

Keywords

Physical activity • Activity monitor • Motion sensor • Accelerometer • Heart failure

*Corresponding author. Department of Health, Medicine and Caring Sciences, Linköping University, Norrköping SE 601 74, Sweden. Tel: +4 611 363629, Fax: +4 611 125448, Email: leonie.klompstra@liu.se

Introduction

Even modest amounts of regular physical activity in patients with heart failure (HF) are associated with a lower risk of HF-related hospital admissions and mortality, and other health-related outcomes.^{1,2} As a result, there are increasing numbers of intervention studies under way exploring the effects of encouraging and increasing physical activity in patients with HF on a variety of primary outcome variables including mortality, morbidity and quality of life.³ Other studies have focussed on measures of functional capacity, either subjective such as New York Heart Association classification, or objective including the 6-min walk test distance, and peak cardiopulmonary capacity via peak oxygen uptake measurement. These assessments are limited by being snapshots of physical function and do not assess long-term physical activity. Many terms are used to describe outcomes related to physical function, such as physical activity, daily physical activity, non-sedentary behaviour and exercise capacity.

Physical activity is defined as bodily movement produced by skeletal muscles that results in energy expenditure.⁴ Both subjective and objective instruments can be used to measure physical activity. Subjective measures include self-reported questionnaires or diaries such as the International Physical Activity Questionnaire (IPAQ) or the Cambridge Physical Activity Index (CPAI), but these are limited by subjectivity, recall bias, or participant burden.^{5–7} Self-reported questionnaires can overestimate physical activity by up to 44% in men and 138% in women, and also lack the precision needed to detect changes in physical activity on a day-to-day basis.⁸

Objective methods to measure physical activity include measures that directly assess one or more dimensions of physical activity (e.g. frequency, intensity, time, type), and have the ability to capture a variety of metrics such as number of steps, minutes of activity, intensity of activity, and bouts of activity.⁹ Commonly used tools include indirect calorimetry and direct observation as well as wearable devices such as step counters, motor sensors, activity monitors (a device or application for monitoring and tracking physical activity). These objective measurements are considered superior to self-reporting physical activity, as they better capture the intricacies of physical activity dimensions.^{10,11} Recently, activity monitors have been used to provide personalized advice, motivate and remind patients to be active, and help them to set realistic goals.¹² Hence, activity monitors that are simpler to use have been proposed as a practical alternative to more formal activity monitors when no accurate measurement is needed, for example in clinical practice.^{13–15}

In a more protocolized clinical setting and for research purposes, activity monitors have been considered to quantify and monitor activity counts objectively and continuously over an extended period of time.¹⁶ Activity monitors that sense body accelerations, commonly known as ‘accelerometers’, capture additional information on the intensity, duration and frequency of physical activity, as well as the number of steps.⁹ These devices can therefore capture physical activity intensity levels and provide a more continuous and comprehensive evaluation of free-living activity.^{17,18} A relevant proportion of HF patients have a cardiac device such as a cardiac pacemaker, an implantable cardioverter-defibrillator, a cardiac

resynchronization therapy device, a wearable shock vest, or ventricular assist devices. Some of these cardiac devices can also measure physical activity in these patients.^{19,20} Finally, smartphone and smartwatch-based applications, such as MyHeart Counts, play a role in measuring physical activity.^{21,22}

Nevertheless, one challenge is that there is no ‘gold standard’ for activity monitoring in research on cardiac patients, leading to a large variety of equipment used and values reported. Such a variety of tools, each with limited validation data, hinders the comparability of results and has delayed the growth of a reliable evidence base in terms of assessing the effect of training interventions and other interventions on activity. The challenges outlined above are exacerbated in patients with HF because of their very low physical activity levels, frailty and abnormalities of cognition, such that not all monitors are suitable in all patients. A recently published review²³ assessed the methods used for collecting and processing accelerometer data in cardiology, but more work is needed to address the challenges of comprehensive and consistent collecting, reporting, and analysing of physical activity in patients with HF.

The aims of this paper were to provide an overview of available activity monitors used in research in patients with HF and to identify the most appropriate criteria in the selection of the most adequate activity monitor for collecting, reporting, and analysing physical activity in HF research.

Methods

This study is conducted in three parts. First, we conducted a systematic literature review to identify important physical activity concepts and activity monitors that have been used in research on patients with HF. Second, we performed an additional scoping review using electronic resources and the manuals for the available activity monitors to describe their validation. Third, the most appropriate criteria in the selection of the most adequate activity monitor were identified from the current literature, and were shared and discussed among the members of the Committee on Exercise Physiology and Training of the Heart Failure Association of the European Society of Cardiology. Next to the design and aim of research to measure physical activity, the validity of the measurement, data storage, data access, completeness and costs were considered important criteria in selection of an activity monitor in HF research.

The literature search included online electronic databases (PubMed, Scopus, CINAHL and Web of Science), and was conducted in October 2017 and updated in April 2020. The following search string was utilized across the databases: (‘accelerometer’ OR ‘accelerometry’ OR ‘motion sensor’ OR ‘activity monitor’) AND (‘heart failure’). For inclusion in this analysis, studies were required to be published or in press, peer-reviewed literature and in the English language. Studies that include patients under 18 years old, studies that were not explicitly related to physical activity and studies that were not specifically related to HF were excluded. Additionally, we excluded studies including pedometers measuring only steps, which are often inaccurate at slow gait speed.²⁴ Measuring steps only can ignore the intensity, duration and frequency of physical activity, which we consider important aspects of measuring physical activity. Two authors (L.K. and M.K.) independently reviewed the results of each search according to the inclusion and exclusion criteria. A third author (E.L.) adjudicated in cases of disagreement.

Table 1 Concepts and definition in activity monitoring

Concept	Description
Activity count	Activity that causes an acceleration signal to exceed a threshold is 'counted' as activity; anything below this threshold is ignored. At the end of a measurement period, the number of activity 'counts' is recorded.
Activity trackers and monitors	Device or application for monitoring and tracking physical activity.
Type (dose)	The type and amount of reported or prescribed physical activity. ²⁵
Time (duration)	The length of time for each session or bout. ²⁵
Frequency	Sessions or bouts of moderate-to-vigorous physical activity per day or per week. ²⁵
Intensity	The rate of energy expenditure required to perform any physical activity. It can be measured in METs, kilocalories, joules, or oxygen consumption.
Energy expenditure	The amount of energy that a person needs to carry out physical functions.
Epoch	A particular period of time in a person's life.
Exercise	A subset of physical activity that is planned, structured and repetitive and has as a final or an intermediate objective the improvement or maintenance of physical fitness. ⁴
Light-intensity activity	Requires 1.6 to less than 3.0 METs; examples include walking at a slow or leisurely pace (2 mph or less), cooking activities, or standing while scanning groceries as a cashier. ²⁶
Metabolic equivalent of task (MET)	The objective measure of the ratio of the rate at which a person expends energy, relative to the mass of that person, while performing some specific physical activity compared to a reference. One MET is the rate of energy expenditure while sitting at rest, which, for most people approximates an oxygen uptake of 3.5 mL/kg/min. The energy expenditure of other activities is expressed in multiples of METs. For example, for the average adult, sitting and reading requires about 1.3 METs. Strolling or walking slowly requires about 2.0 METs. Walking at about 3.0 miles/h requires about 3.3 METs, and running at 5 miles/h requires about 8.3 METs. The average rate of energy expenditure for a substantial number of activities has been documented for the general adult population. ²⁶
Moderate-intensity activity	Requires 3.0 to less than 6.0 METs; examples include walking briskly or with purpose (3 to 4 mph), mopping or vacuuming, or raking a yard. ²⁶
Physical activity	Any bodily movement produced by skeletal muscles that results in energy expenditure. ⁴
Sedentary behaviour	Any waking behavior characterized by an energy expenditure of 1.5 or fewer METs while sitting, reclining, or lying. ²⁷
Uniaxial, biaxial and triaxial	Uniaxial activity monitors measure acceleration in one plane, usually vertical to the ground. Biaxial and triaxial refer to activity monitors which measure acceleration in two or three planes, respectively.
Vigorous-intensity activity	Requires 6.0 or greater METs; examples include walking very fast (4.5 to 5 mph), running, carrying heavy groceries or other loads upstairs, shoveling snow by hand, mowing grass with a hand-push mower, or participating in an aerobics class. ²⁶
Vector magnitude unit	The vectorial sum of activity in the three orthogonal directions measured over a 1-min period.
Volume	The quantification of the dose of activity accumulated over a specified length of time. In activity monitors, volume are activity counts or step counts during a set period of time. ²⁵

Results

Overall, 45 studies from 489 publications were identified as relevant, and full copies were retrieved and assessed (online supplementary Figure S1 and Table S1).

Concepts related to physical activity

The most frequently used concepts in research on activity monitors were physical activity and exercise (Table 1).^{4,25–27} Physical activity is any bodily movement produced by skeletal muscles that results in energy expenditure. Exercise is a subset of physical activity, but it is planned, structured and repetitive, and its final or intermediate objective is the improvement or maintenance of physical fitness.⁴ Physical activity or exercise is prescribed by health care professionals to their patients with HF following the FITT principle (frequency, intensity, time/duration and type). The frequency describes the number of sessions of physical activity per

day or per week, and the intensity is the rate of energy expenditure (sedentary-light-moderate to vigorous) required to perform any physical activity.²⁵ 'Type' indicates the characteristics and the amount of prescribed physical activity, while 'time' describes the duration of each session. Most activity monitors measure activity counts and/or step counts, where activity counts are acceleration signals that exceed a threshold and are therefore 'counted' as activity.

Activity monitors in heart failure research

Seventeen activity monitors were described in the retrieved articles on patients with HF (Table 2).^{28–43} Of these 17 activity monitors, eight [Actical (Minimitter, Inc., Respironics, Bend, OR, USA), ActiGraph Model GT1M Model and ActiGraph 7164 (ActiGraph, Pensacola, FL, USA), ActivPAL™ (PAL Technologies Ltd., Glasgow, UK), Caltrac (Muscle Dynamics, Torrance, CA, USA), the Chiron

Table 2 Characteristics of activity monitors used in research with patients with heart failure

Activity monitor	Size (weight)	Placement	Costs	Data storage	Water resistance	Can assess sleep quality	Outcome (measured)	Outcome (calculated)	Field validation TEE & AEE	Laboratory validation
Uniaxial										
KenzLifeRecorder EX (KenzLifeRecorder; Suzuken Co., Ltd., Nagoya, Japan)	7.25 × 4.15 × 2.75 cm (60 g)	Waist	10 € Software for free: Physical Activity Analysis Software (PAAAS)	200 days	No	No	Steps, activity intensity level	EE, activity intensity level	TEE healthy adults r = 0.83 ²⁸	Healthy adults r = 0.56–0.96 ^{28–31}
Triaxial										
Actigraph GT3X (Actigraph, Pensacola, FL, USA)	4.6 × 3.3 × 1.5 cm (19 g)	Hip, ankle, or wrist	1385 Euros for monitor, interface unit, and software	19 days	To 1 m	Yes	AC, physical activity intensity, steps	EE, activity intensity level	TEE healthy adults r = 0.80 ²⁸	Healthy adults r = 0.88 ²⁸
AX3 (Activity Ltd, Newcastle, UK)	23 × 32.5 × 7.6 mm (11 g)	Wrist	124 €, 135 € with wristband Software is open source	14 days (110 Hz)	To 1.5 m	No	AC, physical activity intensity	EE, activity intensity level	TEE healthy adults r = 0.87–0.91 ³² AEE healthy adults r = 0.59–0.69 ³²	Stroke patients r = 0.63–0.87 ³³
Fibit-Flex (Fibit Inc., San Francisco, CA, USA)	31.7 × 8.9 × 6.8 mm (23.53 g)	Wrist	60 €	5 days	Sweat, rain and splash-proof	Yes	AC, physical activity intensity, steps	EE, activity intensity level	TEE healthy adults r = 0.84 ²⁸	Healthy adults r = 0.90 ²⁸
Stayhealthy RT3 (Stayhealthy, Monrovia, CA, USA)	7.1 × 5.6 × 2.8 cm (65.2 g)	Hip or waist	462 € for monitor and docking station	21 days	To 1 m	No	AC, VMU	EE	TEE healthy adults r = 0.32 ³⁴	Healthy/overweight adults r = 0.47 ³⁵
TracmorD (Philips New Wellness Solutions, Lifestyle Incubator, The Netherlands)	3.2 × 3.2 × 0.5 cm (12.5 g)	Around the neck, hip, or on lower back	99 €, 15 € monthlyabonnement software online	22 weeks	To 3 m	Yes	AC, physical activity intensity	EE, activity intensity level	TEE healthy adults r = 0.46 ⁴⁰ AEE healthy adults r = 0.48 ⁴⁰	Healthy adults r = 0.48–0.94 ^{36–39} Healthy subjects r = 0.89 ⁴¹
Multisensor										
Fibit Charge HR (Fibit Inc., San Francisco, CA, USA)	Wrist 31.7 × 8.9 × 6.8 mm (23.53 g)		149 €	5 days	Sweat, rain and splash-proof	Yes	AC, physical activity intensity, steps	EE, activity intensity level	X	X
GENEAktiv (Activinsights Ltd., Camps, UK)	43 × 40 × 13 mm (16 g)		205 €	7 days	Waterproof	Yes	AC, physical activity intensity	EE, activity intensity level	X	Healthy adults r = 0.97 ⁴²
Move 4 (Movisens, GmbH, Karlsruhe, Germany)	62.3 × 38.6 × 11.5 mm (25 g)	Hip, wrist, or chest	2115 € for monitor, interface unit, and software. The possibilities to rent the device for 50 € a week	7 days	Sweat, rain and splash-proof	No	AC, physical activity intensity, steps	EE, activity intensity level	X	Move II healthy adults r = 0.64–0.88 ⁴³

AC, activity count; AEE, active energy expenditure; TEE, total energy expenditure; VMU, vector magnitude unit.

Table 3 Cut-off points for sedentary time, light physical activity, moderate physical activity and vigorous activity in adults and older adults

Age group	Sedentary time	Physical activity		
		Light	Moderate	Vigorous
Adults				
Freedson <i>et al.</i> ⁴⁴	≤99	100–759	760–5724	≥5725
Troiano <i>et al.</i> ⁴⁵	≤100	101–2019	2020–5998	≥5998
Older adults				
Copeland <i>et al.</i> ⁴⁶	≤99	100–1039	≥1040	NA
Davis and Fox ⁴⁷	≤199	200–1999	2000–3999	≥4000
Metzger <i>et al.</i> ⁴⁸	≤149	150–2019	≥2020	NA
Troiano <i>et al.</i> ⁴⁵	≤100	101–2019	2020–5997	≥5998

NA, not available.

wearable sensor platform, SenseWear Pro3 Armband (BodyMedia, Inc, Pittsburgh, PA, USA) and the Temec activity monitor (Temec Instruments Kerkrade, The Netherlands)] were not available or not yet available to purchase on the market and therefore were not considered. One activity monitor, the HJA-750C Active Style Pro (OMRON Healthcare Co., Ltd., Kyoto, Japan), despite being available outside Japan, only provided software and supporting information in Japanese. This device was also not considered. Another activity monitor, the Move II (Movisens, GmbH, Karlsruhe, Germany), was no longer available, but had been replaced with the Move 4 (Movisens, GmbH, Karlsruhe, Germany) which has all the functionality of the Move II, with user-relevant improvements including better battery longevity and improved water-resistant casing. Given the availability of information on the Move II, we considered the potential of the Move 4 for patients with HF.

The remaining monitors ($n = 9$) were subsequently classified into three groups: uniaxial, triaxial and multisensory. Table 2 presents data on basic characteristics such as the size, weight, placement, costs, data storage, water resistance, possibilities to measure length and quality of sleep, outcomes and validation of these activity monitors.

Uniaxial activity monitors

Uniaxial monitors measure the degree and intensity of movement in a vertical plane, by identifying periods of standing and stepping activity. Only one activity monitor, the Kenz Lifecorder EX (Suzuken Co., Ltd., Nagoya, Japan), has been used in HF research and is still available. This device (dimensions: $7.25 \times 4.15 \times 2.75$ cm) is worn on the thigh or over the hip, and measures steps. It is not water resistant. The memory capacity allows activity and posture to be recorded continuously for periods of up to 200 days. Data can be transferred with a USB cable to a personal computer running Windows 98SE/Millennium/2000 and XP only.

Triaxial activity monitors

Triaxial activity monitors measure multidirectional movement more efficiently. We identified five triaxial monitors that had been

used in HF research: ActiGraph GT3X, AX3, Fitbit Flex, Stayhealthy RT3 and TracmorD. Most of these are worn using an elastic belt or in a clip pouch on the hip or waist. The TracmorD can also be worn as a necklace or on the lower back. One monitor was sweat, rain and splash proof (Fitbit Flex), while two were waterproof up to 1 m (ActiGraph GT3X and Stayhealthy RT3), one up to 1.5 m (AX3) and one up to 3 m (TracmorD). Most of these are acceptably small (ranging from $23 \times 32.5 \times 7.6$ mm to $71 \times 56 \times 28$ mm) and all of them convert accelerations into activity count values, allowing energy expenditure to be calculated. The sum of activity counts in an epoch is linearly related to activity intensity and can be classified into intensities of physical activity based on validated and established activity count cut points (Table 3).^{44–48}

The monitors differ in terms of memory capacity: the ActiGraph memory allows activity and posture to be recorded continuously for periods of up to 19 days, the Actical up to 45 days, the Stayhealthy RT3 up to 21 days, the Move 4 up to 7 days, the Fitbit Flex up to 5 days, and the TracmorD up to 22 weeks. With some activity monitors, software (compatible with a Windows operating system) is needed to download the data (ActiGraph GT3X, AX3, Stayhealthy RT3) to a personal computer, while with others (Fitbit Flex and TracmorD) the data can be uploaded to a website online, in an online cloud. One activity monitor (ActiGraph) has the option to buy a data hub, which allows data to be transferred (in encrypted form) through a Bluetooth connection to an online cloud.

Multisensory activity monitors

The Fitbit Charge HR, the GENEActiv and the Move 4 are multisensory triaxial activity monitors. The Fitbit Charge HR incorporates a heart rate sensor, the Move 4 has a rotation rate sensor, a pressure sensor and a temperature sensor, and the GENEActiv has an ambient light and temperature sensor. These are small devices (ranging from $43 \times 40 \times 13$ mm to $62.3 \times 38.6 \times 11.5$ mm) that can be worn on the wrist, although the Move 4 can also be worn on the hip or the chest. Two monitors were sweat, rain and splash proof (Fitbit Charge HR and Move 4), while the GENEActiv is totally waterproof. The Fitbit Charge has a battery longevity of

5 days, and the GENEActiv and Move 4 have a battery longevity of 7 days.

For data transfer, two multisensory activity monitors (GENEActiv and Move 4) need to be connected via a USB cable to a personal computer with a software developed for the specific monitor (applicable for Windows operating systems). One activity monitor needs to be connected via a USB cable to a personal computer, where the data can be uploaded to a website (online cloud).

Validation of the activity monitors

For this report we have divided the validation evidence into that collected in the field and that collected in the laboratory (Table 2). Field validation is validation of an activity monitor against indirect calorimetry, using the doubly labelled water technique (the gold standard). In the doubly labelled water technique, participants are given a known volume of water which contains 'marker isotopes'. Over a period of days or weeks, samples of body water (from saliva, urine or blood plasma) are assessed for the elimination of these isotopes, which occurs through the body's metabolism. There is a direct correlation between energy expenditure and the amount of carbon dioxide and metabolic water produced. The changes in the isotopes in the body water over time are linked to oxygen usage and carbon dioxide production, both of which are major biochemical components of energy metabolism.⁴⁹ Correlation coefficients between total and active energy expenditure measured by the activity monitor and total and active energy expenditure measured with doubly labelled water were extracted.

Laboratory validation involves the comparison of data obtained from the monitor against data from indirect calorimetry during exercise, using either a metabolic cart, a metabolic chamber or direct observation. A metabolic cart measures the oxygen consumed and the carbon dioxide produced by a subject, and then calculates the energy expenditure. A metabolic chamber measures the amount of heat (energy) produced by a subject enclosed within a chamber. With indirect calorimetry, the amount of heat (energy) produced by a subject is measured by determining the amount of oxygen consumed and the quantity of carbon dioxide eliminated. Correlation coefficients between activity monitor outcome and energy expenditure measured by metabolic cart/chamber were extracted.

Field validation

We first analysed studies that included validation of the total energy expenditure activity monitor against the total energy expenditure measured with doubly labelled water. The total energy expenditure for the GENEActiv and the Move 4 was not validated with doubly labelled water. The total energy expenditure was validated in healthy adults using the Kenz Lifecorder ($r = 0.83$), the ActiGraph GT3X ($r = 0.80$), the AX3 ($r = 0.87$ – 0.91), the Fitbit Flex ($r = 0.84$), the Stayhealthy RT3 ($r = 0.32$) and the TracmorD ($r = 0.48$).

Second, we analysed studies that included the validation of the active energy expenditure measured with the activity monitor against the active energy expenditure measured with doubly labelled water.

The active energy expenditure was validated in healthy adults using the AX3 ($r = 0.59$ – 0.69) and the TracmorD ($r = 0.48$). The active energy expenditure was validated in patients with a chronic disease using the Stayhealthy RT3 ($r = 0.67$).

Laboratory validation

For the laboratory validation, we looked at the correlations between the activity monitor outcomes and the total energy expenditure measures from indirect calorimetry during laboratory protocols. The Fitbit Charge HR was not validated by laboratory validation. The laboratory validation was carried out on healthy adults using the Kenz Lifecorder ($r = 0.56$ – 0.96), the ActiGraph GT3X ($r = 0.88$), the Fitbit Flex ($r = 0.90$), the Stayhealthy RT3 ($r = 0.48$ – 0.94), the TracmorD ($r = 0.89$) and the GENEActiv ($r = 0.97$). The AX3 was laboratory validated for stroke patients ($r = 0.63$ – 0.87), the Stayhealthy RT3 was validated for healthy and overweight adults ($r = 0.47$), and the GENEActiv was validated for patients with HF.

Discussion

Researchers who either study physical activity in patients with HF or wish to assess the effects of interventions on physical activity face the challenge of choosing the most appropriate monitor for the patient group and the intervention. The difficulties are compounded because no overview exists of the utility of these devices regarding practical and scientific issues. With this paper we have therefore summarized the practical and scientific differences between activity monitors used for research patients with HF.

Decide on the aims

The choice of a monitor should depend on the research aims and design regarding physical activity. For non-pharmacological interventions the aim could be to motivate patients to be active or set goals. A less rigorously tested tool can be considered (e.g. activity tracker, smartphone apps^{50,51}). In non-pharmacological and pharmacological interventions, the aim could also be to measure physical activity and its changes over time, such that it is important to choose a valid and reliable activity monitor.

Consider validation

For research purposes, an activity monitor validated with the gold standard (doubly labelled water) is preferred. Three activity monitors, the Fitbit Charge HR, the GENEActiv and the Move 4, were not field validated.

Also, it is important to use validated cut-off points for physical activity levels in patients with HF. Cut-off point to investigate the relationship between activity counts and activity intensity level, should be chosen according to the population that is studied.

Most studies investigating the relationship between activity counts and activity intensity levels in adults, present cut-off points for light, moderate and vigorous physical activity. It is important to note that cut-offs validated in a specific age group might not be valid for other age groups due to different physical activity patterns. Also, in assessing physical intensity levels in patients with HF, we believe that monitoring of sedentary time is important. Therefore, we recommend to use cut-off points for adult patients with HF that can calculate activity counts in sedentary physical activity as moderate to vigorous physical activity (Table 3).^{44,45}

Only a few have investigated cut-off points for older adults, such as the typical HF population.^{45–48} When the study population are the elderly HF patients (with possible multi-comorbid disorders and frailty conditions), we recommend using cut-offs that are advised for use in older adults (Table 3) due to different moving patterns between these groups.

Consider data storage, data access and completeness

Data storage is another important feature when choosing the right activity monitor. An accurate measure of physical activity requires at least 4 days of activity data, with a minimum use of 540 min/day.⁵² This determines the required battery longevity and the memory capacity. However, if compliance is imperfect, an activity monitor with a larger storage capacity (at least one week) and a battery longevity that does not require frequent charging is recommended for use. For example, the Fitbit Flex and the Fitbit Charge HR have data storage of only 5 days and require frequent charging.

One aspect that is increasingly relevant to all research is the ability to compare data across studies. This was also included in a literature review²³ looking at the methods used for collecting physical activity data in patients with HF. Researchers and clinicians are encouraged to improve the quality and transparency of data collection and processing.

The key to success in this field, therefore, is that devices must be able to provide raw activity data (activity counts) which can then be translated into activity intensity levels. Uniaxial devices provide raw activity counts in one plane only, usually vertical to the ground, translated into number of steps. Since physical activity is often more complex than simple steps, this might not be sufficient for detailed assessment in clinical practice and is unlikely to be useful for research purposes. The data from biaxial, triaxial or multisensory activity monitors are likely to provide a more complete impression. However, we could not find any research on patients with HF using biaxial activity monitors, and the TracmorD software does not give the raw data in activity counts and activity intensity. It is also unclear which cut-offs are programmed in the analysis software to calculate the activity counts and to translate these into activity intensity levels. The TracmorD, Fitbit Flex and Fitbit Charge HR activity monitors are now only available as commercial devices. As a consequence, the collected data are uploaded to a cloud-based storage system, which patients and researchers do not own themselves. As a result, access to the activity counts could be challenging. Cloud-based data also involve ethical issues in clinical research.

Consider costs

Another consideration when choosing an activity monitor is costs, which range between € 10 for a uniaxial monitor and € 2115 for a multisensory monitor. One monitor could be rented for periods of time.

Limitation and future directions

Unfortunately, it is often not possible to field validate activity monitors due to the costs of doubly labelled water testing, the 'gold standard'. Because the doubly labelled water technique is based on body's metabolism, and this will not change due to HF, we believe that devices that are field validated are also considered as validated devices for patients with HF.

When it is not possible to field validate an activity monitor, laboratory validation could be a solution. Unfortunately, we found only laboratory validation in healthy adults, overweight adults or stroke patients but no data around validation in patients with HF. Future research should focus on either field validation of new devices or laboratory validation of devices in patients with HF. Since HF includes a wide variety of phenotypes, with widely differing left ventricular ejection fraction and conditioning levels, an effort to be able to analyse these distinctions with activity monitors, providing a precise phenotype-driven cut-off point, should be pursued.

Pre-determined decisions about data collection (e.g. activity monitor placement, wear time) and processing (e.g. non-wear-time definition, cut-off points) in relation to the study participants and the objective of the study are important when planning research in this area.⁵³

Physical activity is the prolongation of cardiac rehabilitation and this was shown to reduce hospitalizations. However, no data exist in a study using activity monitors that showed a reduction in hospitalizations. In order to understand the relationship between physical activity and (re)hospitalization, future research should focus on monitoring patient their long-term physical activity to detect possible deterioration. We also believe that future research should explore the relation between physical activity and traditional measures of functional status (e.g. New York Heart Association class, 6-min walk test, cardiopulmonary exercise testing).

The development of activity monitors is evolving rapidly and therefore we aim to update the data on available activity monitors used in HF research regularly.

Conclusions

The choice of a monitor should depend on the research aims and design regarding physical activity. If the aim is to motivate patients to be active or set goals, a less rigorously tested tool can be considered, such as step counters or smartphone/watch applications. On the other hand, if the aim is to measure physical activity and its changes over time or with treatment, it is important to choose a validated activity monitor (preferable with field validation) and choose activity intensity cut-offs points that are appropriate for the elderly co-morbid population commonly represented in HF. Furthermore, the device needs to have a storage with battery longevity

of at least one week to be able to compare to other research, and must be able to provide raw data. Other considerations in choosing an activity monitor should be where the data are stored, who owns the collected physical activity data and the costs. This article summarizes the practical and scientific differences between activity monitors used in research on patients with HF, to help researchers who study physical activity in patients with HF and who design and evaluate interventions to choose the most appropriate monitor for their requirements.

Supplementary Information

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Conflict of interest: none to declare related to this work. Outside of this work, in the last 3 years, A.J.S.C. declares having received honoraria and/or lecture fees from AstraZeneca, Bayer, Boehringer Ingelheim, Menarini, Novartis, Nutricia, Servier, Vifor, Actimed, Arena, Cardiac Dimensions, Corvia, CVRx, Enopace, ESN Cleer, Faraday, Gore, Impulse Dynamics, Respicardia.

References

- Ponikowski P, Voors AA, Anker SD, Bueno H, Cleland JG, Coats AJ, Falk V, González-Juanatey JR, Harjola VP, Jankowska EA, Jessup M, Linde C, Nihoyannopoulos P, Parissis JT, Pieske B, Riley JP, Rosano GM, Ruilope LM, Ruschitzka F, Rutten FH, van der Meer P; ESC Scientific Document Group. 2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure: the Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC). Developed with the special contribution of the Heart Failure Association (HFA) of the ESC. *Eur J Heart Fail* 2016;**18**:891–975.
- Guazzi M, Dickstein K, Vicenzi M, Ross A. Six-minute walk test and cardiopulmonary exercise testing in chronic heart failure: a comparative analysis on clinical and prognostic insights. *Circulation* 2009;**2**:549–555.
- Taylor RS, Walker S, Smart NA, Piepoli MF, Warren FC, Ciani O, O'Connor C, Whellan D, Keteyian SJ, Coats A, Davos CH, Dalal HM, Dracup K, Evangelista L, Jolly K, Myers J, McKelvie RS, Nilsson BB, Passino C, Witham MD, Yeh GY, Zwisler AD; ExTraMATCH II Collaboration. Impact of exercise-based cardiac rehabilitation in patients with heart failure (ExTraMATCH II) on mortality and hospitalisation: an individual patient data meta-analysis of randomised trials. *Eur J Heart Fail* 2018;**20**:1735–1743.
- Caspersen CJ, Powell KE, Christenson GM. Physical activity, exercise, and physical fitness: definitions and distinctions for health-related research. *Public Health Rep* 1985;**100**:126.
- Alharbi M, Bauman A, Neuback L, Gallagher R. Measuring overall physical activity for cardiac rehabilitation participants: a review of the literature. *Heart Lung Circ* 2017;**26**:1008–1025.
- Deka P, Pozehl B, Norman JF, Khazanchi D. Feasibility of using the Fitbit® charge HR in validating self-reported exercise diaries in a community setting in patients with heart failure. *Eur J Cardiovasc Nurs* 2018;**17**:605–611.
- Chiala O, Vellone E, Klompstra L, Ortali GA, Stromberg A, Jaarsma T. Relationships between exercise capacity and anxiety, depression, and cognition in patients with heart failure. *Heart Lung* 2018;**47**:465–470.
- Prince SA, Adamo KB, Hamel ME, Hardt J, Connor Gorber S, Tremblay M. A comparison of direct versus self-report measures for assessing physical activity in adults: a systematic review. *Int J Behav Nutr Phys Act* 2008;**5**:56.
- Strath SJ, Kaminsky LA, Ainsworth BE, Ekelund U, Freedson PS, Gary RA, Richardson CR, Smith DT, Swartz AM; American Heart Association Physical Activity Committee of the Council on Lifestyle and Cardiometabolic Health and Cardiovascular, Exercise, Cardiac Rehabilitation and Prevention Committee of the Council on Clinical Cardiology, and Council on Cardiovascular and Stroke Nursing. Guide to the assessment of physical activity: clinical and research applications: a scientific statement from the American Heart Association. *Circulation* 2013;**128**:2259–2279.
- Kelly P, Fitzsimons C, Baker G. Should we reframe how we think about physical activity and sedentary behaviour measurement? Validity and reliability reconsidered. *Int J Behav Nutr Phys Act* 2016;**13**:32.
- Marin TS, Kourbelis C, Foote J, Newman P, Brown A, Daniel M, Coffee NT, Nicholls SJ, Ganesan A, Versace VL, Beks H, Haedtker CA, Clark RA. Examining adherence to activity monitoring devices to improve physical activity in adults with cardiovascular disease: a systematic review. *Eur J Prev Cardiol* 2019;**26**:382–397.
- Jaarsma T, Klompstra L, Strömberg A. *The Rise of Activity Monitoring*. London, UK: SAGE Publications; 2019.
- Alharbi M, Straiton N, Gallagher R. Harnessing the potential of wearable activity trackers for heart failure self-care. *Curr Heart Fail Rep* 2017;**14**:23–29.
- Villani GQ, Villani A, Zanni A, Sticozzi C, Maceda DP, Rossi L, Pisati MS, Piepoli MF. Mobile health and implantable cardiac devices: patients' expectations. *Eur J Prev Cardiol* 2019;**26**:920–927.
- Jaarsma T, Klompstra L, Strömberg A. The rise of activity monitoring. *Eur J Prev Cardiol* 2019;**26**:380–381.
- Ridgers ND, Fairclough S. Assessing free-living physical activity using accelerometry: practical issues for researchers and practitioners. *Eur J Sport Sci* 2011;**11**:205–213.
- Yang CC, Hsu YL. A review of accelerometry-based wearable motion detectors for physical activity monitoring. *Sensors* 2010;**10**:7772–7788.
- Silfee VJ, Haughton CF, Jake-Schoffman DE, Lopez-Cepero A, May CN, Sreedhara M, Rosal MC, Lemon SC. Objective measurement of physical activity outcomes in lifestyle interventions among adults: a systematic review. *Prev Med Rep* 2018;**11**:74–80.
- Rosman L, Lampert R, Sears SF, Burg MM. Measuring physical activity with implanted cardiac devices: a systematic review. *J Am Heart Assoc* 2018;**7**:e008663.
- Conraads VM, Spruit MA, Braunschweig F, Cowie MR, Tavazzi L, Borggreve M, Hill MR, Jacobs S, Gerritse B, van Veldhuisen DJ. Physical activity measured with implanted devices predicts patient outcome in chronic heart failure. *Circ Heart Fail* 2014;**7**:279–287.
- Bort-Roig J, Gilson ND, Puig-Ribera A, Contreras RS, Trost SG. Measuring and influencing physical activity with smartphone technology: a systematic review. *Sports Med* 2014;**44**:671–686.
- Hershman SG, Bot BM, Shcherbina A, Doerr M, Moayed Y, Pavlovic A, Waggott D, Cho MK, Rosenberger ME, Haskell WL, Myers J, Champagne MA, Mignot E, Salvi D, Landray M, Tarassenko L, Harrington RA, Yeung AC, McConnell MV, Ashley EA. Physical activity, sleep and cardiovascular health data for 50 000 individuals from the MyHeart Counts Study. *Sci Data* 2019;**6**:24.
- Vetrovsky T, Clark C, Bisi MC, Siranec M, Linhart A, Tufano JJ, Duncan MJ, Belohlavek J. Advances in accelerometry for cardiovascular patients: a systematic review with practical recommendations. *ESC Heart Fail* 2020;**7**:2021–2031.
- Vetrovsky T, Siranec M, Marencakova J, Tufano JJ, Capek V, Bunc V, Belohlavek J. Validity of six consumer-level activity monitors for measuring steps in patients with chronic heart failure. *PLoS One* 2019;**14**:e0222569.
- Physical Activity Guidelines Advisory Committee. *2018 Physical Activity Guidelines Advisory Committee Scientific Report*. Washington, DC: US Department of Health and Human Services; 2018.
- Ainsworth BE, Haskell WL, Herrmann SD, Meckes N, Bassett DR Jr, Tudor-Locke C, Greer JL, Vezina J, Whitt-Glover MC, Leon AS. 2011 Compendium of physical activities: a second update of codes and MET values. *Med Sci Sports Exerc* 2011;**43**:1575–1581.
- Tremblay MS, Aubert S, Barnes JD, Saunders TJ, Carson V, Latimer-Cheung AE, Chastin SF, Altenburg TM, Chinapaw MJ; SBRN Terminology Consensus Project Participants. Sedentary Behavior Research Network (SBRN) – Terminology Consensus Project process and outcome. *Int J Behav Nutr Phys Act* 2017;**14**:75.
- Murakami H, Kawakami R, Nakae S, Nakata Y, Ishikawa-Takata K, Tanaka S, Miyachi M. Accuracy of wearable devices for estimating total energy expenditure: comparison with metabolic chamber and doubly labeled water method. *JAMA Intern Med* 2016;**176**:702–703.
- Kumahara H, Schutz Y, Ayabe M, Yoshioka M, Yoshitake Y, Shindo M, Ishii K, Tanaka H. The use of uniaxial accelerometry for the assessment of physical-activity-related energy expenditure: a validation study against whole-body indirect calorimetry. *Br J Nutr* 2004;**91**:235–243.
- Abel MG, Hannon JC, Sell K, Lillie T, Conlin G, Anderson D. Validation of the Kenz Lifecorder EX and ActiGraph GT1M accelerometers for walking and running in adults. *Appl Physiol Nutr Metab* 2008;**33**:1155–1164.
- Bassett DR. Validity of four motion sensors in measuring moderate intensity physical activity. *Med Sci Sports Exerc* 2000;**32**(9 Suppl):S471–S480.
- White T, Westgate K, Hollidge S, Venables M, Olivier P, Wareham N, Brage S. Estimating energy expenditure from wrist and thigh accelerometry in free-living adults: a doubly labelled water study. *Int J Obes* 2019;**43**:2333–2342.
- Moore SA, Hickey A, Lord S, Del Din S, Godfrey A, Rochester L. Comprehensive measurement of stroke gait characteristics with a single accelerometer in the

- laboratory and community: a feasibility, validity and reliability study. *J Neuroeng Rehabil* 2017;**14**:130.
34. Maddison R, Jiang Y, Vander Hoorn S, Ni Mhurchu C, Lawes CM, Rodgers A, Rush E. Estimating energy expenditure with the RT3 triaxial accelerometer. *Res Q Exerc Sport* 2009;**80**:249–256.
 35. Jacobi D, Perrin AE, Grosman N, Doré MF, Normand S, Oppert JM, Simon C. Physical activity-related energy expenditure with the RT3 and TriTrac accelerometers in overweight adults. *Obesity* 2007;**15**:950–956.
 36. DeVoe D, Gotshall R, McArthur T. Comparison of the RT3 Research Tracker and Tritrac R3D accelerometers. *Percept Mot Skills* 2003;**97**:510–518.
 37. Stone MR, Esliger DW, Tremblay MS. Comparative validity assessment of five activity monitors: does being a child matter? *Pediatr Exerc Sci* 2007;**19**:291–309.
 38. King GA, Torres N, Potter C, Brooks TJ, Coleman KJ. Comparison of activity monitors to estimate energy cost of treadmill exercise. *Med Sci Sports Exerc* 2004;**36**:1244–1251.
 39. Howe CA, Staudenmayer JW, Freedson PS. Accelerometer prediction of energy expenditure: vector magnitude versus vertical axis. *Med Sci Sports Exerc* 2009;**41**:2199–2206.
 40. Bonomi AG, Plasqui G, Goris AH, Westterterp KR. Estimation of free-living energy expenditure using a novel activity monitor designed to minimize obtrusiveness. *Obesity* 2010;**18**:1845–1851.
 41. Bouten CV, Westterterp KR, Verduin M, Janssen JD. Assessment of energy expenditure for physical activity using a triaxial accelerometer. *Med Sci Sports Exerc* 1994;**26**:1516–1523.
 42. Esliger DW, Rowlands AV, Hurst TL, Catt M, Murray P, Eston RG. Validation of the GENE accelerometer. *Med Sci Sports Exerc* 2011;**43**:1085–1093.
 43. Anastasopoulou P, Tubic M, Schmidt S, Neumann R, Woll A, Härtel S. Validation and comparison of two methods to assess human energy expenditure during free-living activities. *PLoS One* 2014;**9**:e90606.
 44. Freedson PS, Melanson E, Sirard J. Calibration of the Computer Science And Applications, Inc. accelerometer. *Med Sci Sports Exerc* 1998;**30**:777–781.
 45. Troiano RP, Berrigan D, Dodd KW, Masse LC, Tilert T, McDowell M. Physical activity in the United States measured by accelerometer. *Med Sci Sports Exerc* 2008;**40**:181–188.
 46. Copeland JL, Esliger DW. Accelerometer assessment of physical activity in active, healthy older adults. *J Aging Phys Act* 2009;**17**:17–30.
 47. Davis MG, Fox KR. Physical activity patterns assessed by accelerometry in older people. *Eur J Appl Physiol* 2007;**100**:581–589.
 48. Metzger JS, Catellier DJ, Evenson KR, Treuth MS, Rosamond WD, Siega-Riz AM. Patterns of objectively measured physical activity in the United States. *Med Sci Sports Exerc* 2008;**40**:630–638.
 49. Schoeller DA, van Santen E. Measurement of energy expenditure in humans by doubly labeled water method. *J Appl Physiol Respir Environ Exerc Physiol* 1982;**53**:955–959.
 50. Seifert A, Schlomann A, Rietz C, Schelling HR. The use of mobile devices for physical activity tracking in older adults' everyday life. *Digit Health* 2017;**3**:205520761774008.
 51. Piotrowicz E, Piepoli MF, Jaarsma T, Lambrinou E, Coats AJ, Schmid JP, Corrà U, Agostoni P, Dickstein K, Seferović PM, Adamopoulos S, Ponikowski PP. Telerehabilitation in heart failure patients: the evidence and the pitfalls. *Int J Cardiol* 2016;**220**:408–413.
 52. Corder K, Brage S, Ekelund U. Accelerometers and pedometers: methodology and clinical application. *Curr Opin Clin Nutr Metab Care* 2007;**10**:597–603.
 53. Migueles JH, Cadenas-Sanchez C, Ekelund U, Delisle Nyström C, Mora-Gonzalez J, Löf M, Labayen I, Ruiz JR, Ortega FB. Accelerometer data collection and processing criteria to assess physical activity and other outcomes: a systematic review and practical considerations. *Sports Med* 2017;**47**:1821–1845.